Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $1,815.00 for dates of service 02/06/01 and 04/18/01.

   b. The request was received on 02/01/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution dated 04/03/02
   b. HCFA(s)-500
   c. TWCC 62 forms
   d. EOB(s) from other insurance carriers
   e. Medical Records
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution dated 04/22/02
   b. HCFA(s)-1500
   d. EOB(s)
   e. Pre-Authorization dated 03/27/01
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 04/08/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 04/11/02. The response from the insurance carrier was received in the Division on 04/22/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor states in the correspondence dated 04/03/02 states, "(*AMA 76005; NOT LISTED IN TWCC 1996 MFG)-Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures….(*AMA 72275; NOT LISTED IN TWCC 1996 MFG)-Epiduragraphy, radiological supervision and interpretation. (76000-Fluoroscopy Tech $88.00) Listed in the TWCC 1996 MFG-Separate procedure,…This is not what we are providing and should be reimbursed at another codes technical value!!….Carrier has not submitted a fair and reasonable methodology of reimbursements….According to AMA, 2002 Current Procedural Terminology, Fourth Edition, (CPT), Instructions for use of CPT, 'Do not select a CPT code that merely approximates the service provided. If no such procedure or service exists, then report the service using the appropriate unlisted procedure or service code....is a freestanding facility….76499-27 (Epiduragram) is a radiologic procedure…Treating doctor has ordered the Fluoroscopic guidance with Epiduragram. It is necessary for the patient to undergo treatment with epidural steroid injections under fluoroscopic guidance with Epiduragram….Our facility bills the appropriate CPT code for what was preauthorized…..Our facility will provide several copies of EOB's from other Work Comp Carriers and Group Health reimbursing according to DOP and reimbursing fluoroscopic guidance with Epiduragram separately."

2. Respondent: The respondent states in the correspondence dated 04/22/02 states, "Regarding the fluoroscopic control billed with CPT code 76499-27-22 : This carrier reimbursed the fluoroscopy per TWCC Medical Fee Guideline maximum allowable reimbursement for the technical component of fluoroscopy, CPT code 76000. This carrier reimbursed the requester $88 with explanation code "M" because the requester used an unlisted code….TWCC's maximum allowable reimbursement for technical component of CPT code 76000 of $88 is fair and reasonable….The American Medical Association, author of CPT codes, stated CPT code 76000 is proper for fluoroscopic guidance….no reimbursement would be due for the fluoroscopy because the fluoroscopy is a component of the epidurogram….It is this carrier's position that it is improper to code for an epidurogram because an epidurogram was not documented and it was not necessary….there is NO formal report evaluating the free flow…of contrast, the condition of the epidural space….the requester's letter dated 04/03/02 states, 'Preauthorization process establishes the medical necessity and reasonableness of the treatment [sic]…. 'However the requester failed to mention the epidurogram was specifically excluded from the preauthorization process and that it would require retrospective review [sic]….It is the carrier's position no additional reimbursement is due for the $10 charge for the syringe billed for surgery in a doctor's office….The charge for the surgical tray should include the charge for 'all the supplies…needed to perform the procedure'….the 'ONLY'

reimbursements allowed for facility charges are sterile tray, anesthesia supplies, and postoperative monitoring….It is this carrier's position that the explanations of benefits from other carriers does [sic] not support that the requester's charges are fair and reasonable. EOBs do not establish or identify payment based on a consistent method as required by Rule 133.304(i)…."

IV. FINDINGS

1. Based on Commission Rule 133.307 (d) (1) (2), the only dates of service eligible for review are 02/06/01 and 04/18/01. Specific CPT codes for date of service 04/18/01 will be addressed in the Dismissal section of this Findings and Decision.

2. The provider listed place of service as "99 – Other Unlisted Facility."

3. ___ is not registered as an approved licensed facility as an ambulatory surgical clinic per the Texas Department of Health in Austin, Texas.

4. The provider received pre-authorization for "Outpatient stay at ___ for ESI X2 #2 & #3 to lumbar. Preauthorization give for requested services prior to 04/26/01…Requested services appear medically necessary. Advised Epidurogram does not require Preauthorization, but will be retrospectively reviewed for medical necessity."

5. The carrier denied billed charges by denial codes, "M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B).",
"CODE – F – N – THE MEDICAL FEE GUIDELINE STATES IN THE IMPORTANCE OF PROPER CODING 'ACCURATE CODING OF SERVICES RENDERED IS ESSENTIAL FOR PROPER REIMBURSEMENT., THE SERVICES PREFORMED [sic] ARE NOT REIMBURSABLE AS BILLED.",
"AUTO F – REIMBURSED IN ACCORDANCE WITH THE TEXAS MEDICAL FEE GUIDELINE.",
"G – 04/01/96 TWCC MEDICAL FEE GUIDELINE GROUND RULES INDICATE THAT THIS SERVICE IS AN INTEGRAL COMPONENT OF ANOTHER SERVICE, PROCEDURE, OR PROGRAM. SEPARATE REIMBURSEMENT IS NOT ALLOWED FOR THIS PROCEDURE.",
"F – REDUCED IN ACCORDANCE WITH THE APPROPRIATE TWCC PER FEE GUIDELINE'S MAXIMUM ALLOWABLE REIMBURSEMENT (MAR).", and
"D – DUPLICATE CHARGE."

6. The carrier's response is timely and no other EOB(s) or medical audits were noted, therefore, the Medical Review Division's decision is rendered based on the denial codes submitted to the provider prior to the date of this dispute being filed.

7. The provider billed $1,815.00 for dates of service, 02/06/01 and 04/18/01.

8. The provider was reimbursed $175.50 for dates of service, 02/06/01 and 04/18/01.

9. The amount in dispute for dates of service, 02/06/01 and 04/18/01, is $1,602.00.

10. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$ (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
02/06/01 04/18/01	76499-27-22 76499-27-22	$300.00 $300.00	$0.00 $0.00	F, N F,M,N	DOP DOP	Medical Fee Guidelines General Instructions (III) (A) (1-3), (VI); Spine Treatment Guideline Rule 134.1001 (e) (2) (T) (i); Rule 133.307 (g) (3) (D); CPT descriptor Rule 133.1 (a) (3) (C)	**TWCC and the Importance of Proper Coding** states, "The accurate coding of services rendered is essential for proper reimbursement…Reimbursement for services is dependent on the accuracy of the coding and documentation." The accurate CPT code for "fluoroscopy" in the Medical Fee Guidelines Radiology/Nuclear Medicine is "76000". The provider failed to use the proper CPT code in billing. The TWCC Spine Treatment Guideline Rule 134.1001 (e) (2) (T) (i) , adopted on 02/01/00, states, "ESIs must be performed under fluoroscopic control." However, the fluoroscopic procedure is a DOP code and the provider failed to meet the required documentation of procedure per MFG GI (III) (A) (1-3) . Under MFG GI (VI), "A MAR is listed for each code excluding documentation of procedure (DOP) codes…HCP's shall bill their usual and customary charges. The insurance company will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate…In the event of a dispute, fair and reasonable shall be determined by the Commission in accordance with the Texas Workers' Compensation Act and Commission rules and procedures." The provider failed to meet the criteria of the DOP procedure.

							Rule 133.307 (g) (3) (D) states, "if the dispute involves healthcare for which the commission has not established a maximum allowable reimbursement documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1…" shall be included in the request for medical dispute resolution. The provider failed to meet the burden of proof that the provider's reimbursement is not fair and reasonable. **No** reimbursement is recommended.

02/06/01 04/18/01	76499-27 76499-27	$300.00 $300.00	F F,N	$0.00 $0.00	DOP DOP	Medical Fee Guidelines General Instructions (III) (A) (1-3), (VI); Rule 133.307 (g) (3) (D); Rule 133.307 (g) (3) (B); Rule 133.1 (a) (3) (E)	Under MFG GI (VI), "A MAR is listed for each code excluding documentation of Procedure (DOP) codes…HCP's shall bill their usual and customary charges. The insurance company will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate…In the event of a dispute, fair and reasonable shall be determined by the Commission in accordance with the Texas Workers' Compensation Act and Commission rules and procedures." The provider failed to meet the criteria of the DOP procedure. Rule 133.307 (g) (3) (D) states, "if the dispute involves healthcare for which the commission has not established a maximum allowable reimbursement documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with § 133.1…" shall be included in the request for medical dispute resolution. The provider failed to meet the burden of proof that the provider's reimbursement is not fair and reasonable. In accordance with Rule 133.307 (g) (3) (B) and Rule 133.1 (a) (3) (E), the provider failed to clearly document the epidurogram procedure in the operative reports for the dates of service. The documented performance of epidurograms for the dates of service is not in evidence. **No** reimbursement is recommended.

02/06/01 02/06/01 04/18/01 04/18/01 04/18/01 04/18/01	A4649 A4209 99499RR A4550 A4649 A4209	$15.00 $10.00 $50.00 $75.00 $15.00 $10.00	G G F,N F F G	$0.00 $0.00 $0.00 $0.00 $0.00 $0.00	DOP DOP DOP DOP DOP DOP	MFG SGR (V) (B) (1-3); GI (III)	Since the provider billed the charged services on the HFCA under the place of service code "99", which does not indicate a doctor's office and the provider is not licensed as an ambulatory surgical center, the determination is that the services will be reviewed as being performed in a doctor's office. MFG SGR (V) (B) (1-3) states, "… the only reimbursements allowed for facility charges shall be the following: …Sterile Trays (which include all supplies, gloves, utensils, needles, suture material, etc., needed to perform the procedure). These shall be billed using 99707-ST. Reimbursement is the lesser of the doctor's usual charge or fair and reasonable reimbursement. DOP is required if charges are $50.00 or greater. …Anesthesia supplies which include the administration of the sedatives, the IV solution, the catheter/tubing , and drugs. No additional charges shall be allowed for equipment or staff. …This service is billed using code 99070-AS. Reimbursement is the lesser of the doctor's usual charge or fair and reasonable reimbursement. DOP is required if charges are $50.00 or greater. …Postoperative monitoring is reimbursed hourly. This service is billed using code 99499-RR, and includes the facility, staffing and monitoring equipment. No separate charges shall be allowed for HCP stand-by. The maximum amount of time allowed for postoperative monitoring is four hours and DOP is required. The provider coded and billed 99499RR (postoperative monitoring) correctly, but did not meet the complete DOP description. The provider failed to code charges according to the MFG and meet DOP. Codes A4649 and A4209 are global according to the SGR. Code A4550 does not meet the criteria of the MFG per SGR. **No** reimbursement is recommended.
Totals		$1,375.00	$0.00				The Requestor **is not** entitled to reimbursement.

The above Findings and Decision are hereby issued this 31st day of May 2002.

Donna M. Myers, B.S.
Medical Dispute Resolution Officer
Medical Review Division

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.

VII. Dismissal

Date of service 04/18/01 the listed CPT codes below are being dismissed. According to Commission Rule 133.307 (m), the Division may dismiss a request if the medical bills in the dispute have not been properly submitted to the carrier pursuant to § 133.304. HCFA(s) for date of service 04/18/01 CPT codes A4215, A4649, 99070AS, and 99070AS were not included in the request for medical dispute resolution. This dismissal does not constitute a decision on this date/these dates of service.